02827

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:

County: Charles

City or town: Newburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

State highway # 301 (U.S.)

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Newburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Arthur Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
48			..... hrs. ..... min.

9. Birthplace: Charles Co

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Ned Brown

13. Birthplace: St Marys Co

MOTHER — 14. Maiden name: Victoria Dunnett

15. Birthplace: near Port Tobacco Md

16. Informant: Ned Brown

Address: Newbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-3-45 (month) (day) (year)

Cemetery or crematory: St Marys

Location: near Port Tobacco Md

18. Funeral director: Hewitt & Lyon

Address: Waldorf Md

19. Apr 3 1945 (Date rec'd by registrar) M. P. McKay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31, 1945 at 10:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31, 1945, to ..... 19..

and that I last saw him on March 31, 1945

Immediate cause of death	DURATION
Crushed chest	2-3 min.
Due to: Automobile accident	
Due to: Struck by hit and run driver	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 3-31-45

Where did injury occur? Newburg, Charles, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) State highway

Means of injury: Struck by auto Injured at work? No

23. SIGNATURE: James L. MacKenzie, M.D. Deputy Medical Examiner M. D. or other

Address: La Plata, Md. Date signed 4-1-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-E

02828

CERTIFICATE OF DEATH

Reg. Dist. No. 104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: Rock Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Longhaven
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary F. Cogher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: Ralph Cogher
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): July 15 1875

8. AGE:

Years	Months	Days	If less than one day
69	7	13	hrs. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business
FATHER 12. Name: Frank Shymansky
13. Birthplace: Poland
MOTHER 14. Maiden name: Mary A. Shymansky
15. Birthplace: Poland
16. Informant: William Stines
Address: Longhaven
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-6-45 (month) (day) (year)
Cemetery or crematory: Holy Ghost
Location: Leonardtown, Md.
18. Funeral director: Hunt & Hyson
Address: Waldorf
19. 3/4 1945 (Date rec'd by registrar) Wallace Free Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-3- 1945, at 7 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944, to 3-3- 1945
and that I last saw h.. alive on 3-3- 1945

	DURATION
Immediate cause of death: Cancer Uterus	2 yrs.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. L. Hyson, M. D. or other
Address: Waldorf Date signed 3-4- 45

Evidence for change of age of deceased is shown on

STATE OF MARYLAND—CERTIFICATE OF DEATH

FILED MAY 15 1945 (937) 02829

1. PLACE OF DEATH

County Charles — Registration Dist. No. 100

Village or City Waysides — No. ____ St., ____ Ward

(If death occurred in a horpital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 7 yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Henry Thaddeus Dyson

(a) Residence: No. Waysides St., Ward. ____

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6. DATE OF BIRTH (month, day, and year): Apr 27 - 1879

7. AGE — Years: 6-4- 65 — Months: 10 — Days: 12 — If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc.: Farmer

9. Industry or business in which work was dona, as SILK MILL, SAW MILL, BANK, etc.: General Farm Work

10. Date deceased last worked at this occupation (month and year): 1944

11. Total tima (years) spent in this occupation: 45

12. BIRTHPLACE (city or town) (State or country): Waysides Charles Md

FATHER

13. NAME: Wm. Henry Dyson

14. BIRTHPLACE (city or town) (State or country): Mt Victoria Charles Md.

MOTHER

15. MAIDEN NAME: Fanny Ann Brown

16. BIRTHPLACE (city or town) (State or country): Compton St Mary's Co. Md.

17. INFORMANT: Ethel K. Lyons

(Address) Mt. Victoria Md

18. BURIAL, CREMATION, OR REMOVAL

Place Shilo. Mt Victoria Md Date 3/18, 19 45

19. UNDERTAKER: Hewitt & Posey

(Address) Waldorf Md

20. FILED 3-17, 19 45 — Julia H. Posey, Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 14 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 1, 1945, to March 7, 1945

I last saw h-im alive on March 7, 1945; death is said to have occurred on the date stated above, at 11.50 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of Importanca were as follows:

	Date of onset
Chronic Myocarditis	1943

Other Contributory Causes of importance: —

Nama of operation None Data of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also tha following:

Accident, suicide, or homicide? Data of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way relatad to occupation of deceasad? No.

If so, specify

(Signed) Ernest Spencer Jr. M. D.

(Address) Bel Air Md

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

U.S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between retail **merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Evidence for change of age is shown on FILM No. G 96 JUN 29 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-E)

02830

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH

County: Charles

City or town: Portabacco md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Charles

City or town: Portabacco md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ida Emma Catherine Gamble

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Alvey Dent Gamble Sr

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 6-12-71

8. AGE: Years	Months	Days	If less than one day
73 ~~74~~	10	17	..... hrs. ..... min.

9. Birthplace: Penna.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace

MOTHER

14. Maiden name: Unknown

15. Birthplace

16. Informant: Mrs Dent Gamble

Address: La Plata Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-1-45 (month) (day) (year)

Cemetery or crematory: Mt Rest

Location: La Plata md

18. Funeral director: Smith & Ryon

Address: Waldorf md

19. April 1 1945 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-29 1945 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-10 1945 to 3-29 1945 and that I last saw her alive on 3-29 1945

Immediate cause of death	DURATION
Congestive Heart Failure	2-16-45
Due to: Hyperthyroid Heart Disease	2-10-45
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D.

M. D. or other

Address: La Plata Md Date signed 3-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

02831

CERTIFICATE OF DEATH

FILM No. G 94 MAY 11 1945

Reg. Dist. No. 342

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Pomonkey Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Nellie Simpson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1883

8. AGE: Years	Months	Days	If less than one day
61	6 mo		..... hrs. ..... min.

9. Birthplace: maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: Phillip Johnson

13. Birthplace: md

MOTHER 14. Maiden name: Virginia Chase

15. Birthplace: md

16. Informant: Edna Barnett daughter

Address: Charles Co. Md. Pomonkey

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-20-45 (month) (day) (year)

Cemetery or crematory: St. Charles cemetary

Location: Glymont, Charles Co. Md.

18. Funeral director: Isaac H. Shade

Address: Hayside Md

19. March 17 1945 (Date rec'd by registrar) Carrint Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16, 1945, at 8:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1945 to March 16, 1945 and that I last saw h.. alive on March 16, 1945

Immediate cause of death	DURATION
Congestive heart failure	2 yrs.
Due to: Essential hypertension	?
Due to:	
Other conditions: Diabetes mellitus	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James L. MacKenzie M.D. M. D. or other

Address: La Plata, Md. Date signed 3-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B3A)

CERTIFICATE OF DEATH

02832

Reg. Diat. No. 100

1. PLACE OF DEATH:
County Charles
City or town Waldorf MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Charles
City or town Waldorf Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Carrie J Lyles

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Negro	Wid

6.(b) Name of husband or wife Ollie Lyles
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Feb 19–1889

8. AGE: Years	Months	Days	If less than one day
56	0	15	..... hrs. ..... min.

9. Birthplace Mt Wardoff MD (Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Isaach Pinckney
13. Birthplace Prince Geo Co

MOTHER
14. Maiden name Annie Pinckney
15. Birthplace Waldorf MD

16. Informant Mildred Marshall
Address 240-14-Place N.E. North DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-8-45 (month) (day) (year)
Cemetery or crematory St Peters
Location Waldorf MD
18. Funeral director Hewitt & Ryon
Address Waldorf Md

19. 3-8 (Date rec'd by registrar) 19 45 Julia H Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 45, at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 37 to 3/5 19 45
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral Apoplexy	
Due to Hypertension	4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. J. Worden M.D.
Address Waldorf Md M. D. or other
Date signed 3/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02833

Reg. Dist. No. 100

1. PLACE OF DEATH

County: Charles

City or town: Rural Waldorf

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Charles

City or town: Rural Waldorf Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Millar

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Lorenza Millar

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1879

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace: Kansas (Town, county, and state)

10. Usual occupation: Printer

11. Industry or business

FATHER — 12. Name: Gideon Millar

FATHER — 13. Birthplace: Ohio

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace

16. Informant: Lorenza "Millar

Address: Waldorf. Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof 3/12/45 (month) (day) (year)

Cemetery or crematory: St. Paul's

Location: Waldorf, Md

18. Funeral director: Hunt & Ryon

Address: Waldorf, Md.

19. 3-12 (Date rec'd by registrar) 19 45 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/10/45, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from M o V 19 44, to 3/10 19 45

and that I last saw h. l. m. alive on 3/9 19 45

Immediate cause of death	DURATION
Cardiac Decompensation	
Due to: Bronchiectasis	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. P. Watson M.D. M. D. or other

Address: Waldorf Md Date signed: 3/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of usual residence of deceased is shown on FILM No. G 95 MAY 29 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

62834

Reg. Diat. No. 100

1. PLACE OF DEATH:
County Charles
City or town La Plata Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Mills

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 18-1884

8. AGE: Years 61 | Months — | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace New Port Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John Mills
13. Birthplace New Port Md

MOTHER
14. Maiden name Caroline Chase
15. Birthplace New Port Md

16. Informant Anna Dyson
Address Beltsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-26-45 (month) (day) (year)
Cemetery or crematory St Ignatius
Location Beltsville Md
18. Funeral director Hunt & Dyson
Address Woodbury Md

19. 3-25-45 (Date rec'd by registrar) 19 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1945, at 8:52 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2, 1945, to March 23 1945 and that I last saw her alive on March 23, 1945

Immediate cause of death	DURATION
Rupture of esophageal varix	2-3 min.
Due to Acute carcinomatosis of breast	4 weeks
Due to (with metastases to liver)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James L. MacKaracgh, M.D. M. D. or other
Address La Plata Md Date signed 3-23-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

02835

Reg. Diat. No. 100

1. PLACE OF DEATH:

County Charles

City or town Waldorf

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

—

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Charles

City or town Waldorf

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Overton Monroe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
80 ?			..... hrs. ..... min.

9. Birthplace (Town, county, and state)

10. Usual occupation Physician

11. Industry or business General practice

FATHER 12. Name H. Daniel Monroe

13. Birthplace Waldorf, Md

MOTHER 14. Maiden name Caroline S. Shoemaker

15. Birthplace Waldorf, Md

16. Informant John R. Monroe

Address 424 W. Saratoga St. Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/10/45 (month) (day) (year)

Cemetery or crematory Oakland

Location Waldorf, Md

18. Funeral director Hewitt & Ryon

Address Waldorf, Md.

19. 3-9 1945 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1945, at 2:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1945, to —— 19—

and that I last saw him alive on March 8, 1945

Immediate cause of death	DURATION
Acute right ventricular failure	2½ hrs.
Due to Arteriosclerotic heart disease	?
Due to Generalized arteriosclerosis	?
Other conditions Diabetes [redacted]	6-7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L. McKaughan, M.D. M. D. or other

Address La Plata, Md. Date signed 3-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of birth date of deceased is shown on FILM No C 9 4 MAY 11 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02836 Reg. Dist. No. 100

1. PLACE OF DEATH:
County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edith Padgett — **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	N	Married

6.(b) Name of husband or wife James Padgett
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Mch 6 45 Feb. 19, 1875

8. AGE: Years	Months	Days	If less than one day
70	0	12	____ hrs. ____ min.

9. Birthplace La Plata Md (Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Alexandria Rees
13. Birthplace Scotland

MOTHER
14. Maiden name Jane Allnutt
15. Birthplace La Plata Md

16. Informant James Padgett
Address La Plata Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-9-45 (month) (day) (year)
Cemetery or crematory Mt Rest
Location La Plata Md
18. Funeral director Hewitt & Ryon
Address Waldorf Md

19. 3-6 (Date rec'd by registrar) 1945 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1945 at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1940 to March 6, 1945 and that I last saw h.er alive on Feb. 26, 1945

Immediate cause of death	DURATION
Purpura hemorrhagica due to cachexia	8 days
Due to Generalized arteriosclerosis	6-7 yrs.
Due to	
Other conditions Chronic rheumatoid arthritis	6-7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James L. MacKaracgh, MD M. D. or other
Address La Plata, Md Date signed 3-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth is shown on FILM [illegible] 4 MAY 11 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

Reg. Dist. No. 02837 100

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Ada T. Saucer

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Philip Ernest [redacted] Saucer
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 15, 1863 - 1862

8. AGE: Years	Months	Days	If less than one day
82	9	25	____ hrs. ____ min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Housf.
11. Industry or business:

FATHER
12. Name: Theodore J. Hunter
13. Birthplace: Mattawoman, Md

MOTHER
14. Maiden name: Elizabeth Turner
15. Birthplace: Mattawoman, Md

16. Informant: Ralph Saucer
Address: 9 Raymond St. Chevy Chase 15, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-14-45 (month) (day) (year)
Cemetery or crematory: Mt Rest
Location: La Plata, Md
18. Funeral director: Hunter & Ryan
Address: Waldorf, Md.

19. Mar. 12 1945 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12, 1945, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June, 1936, to March 12, 1945
and that I last saw h. on alive on March 10, 1945

Immediate cause of death	DURATION
Acute rt. ventricular failure	15-20 min.
Due to: Chronic myocardosis	9 yrs.
Due to:	
Other conditions: Acute tracheitis	2 wks.

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James L. MacKavanagh M.D.
M. D. or other
Address: La Plata, Md. Date signed 3-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

02838

Reg. Diat. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: Waldorf, (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Charles
City or town: Waldorf, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George Malcolm Shelor, GEORGE MALCOLM
3. (b) Social Security Number: 579-16-7058

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband~~ or wife: Nellie May Shelor
6.(c) If alive, give age: 44 years
7. Birth date of deceased (mo., day, yr.): april 3, 1885

8. AGE: Years: 59 | Months: 11 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Meadows of Dan Va. (Town, county, and state)
10. Usual occupation: Powder factory attendant
11. Industry or business:
FATHER 12. Name: Frank Shelor
13. Birthplace: Va.
MOTHER 14. Maiden name: Nellie Spangler
15. Birthplace: Va.
16. Informant: Nellie May Shelor
Address: Waldorf, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/11/45 (month) (day) (year)
Cemetery or crematory: Oakland
Location: Waldorf, Md
18. Funeral director: Hunt & Bryan
Address: Waldorf Md.
19. 3-10 19 45 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/8/45 at 5 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/8/45 to 3/8/45
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Arterio-Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: C. D. Wadey M. D. (M. D. or other)
Address: Waldorf Md Date signed 3/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

02839

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:
County: Charles
City or town: Marbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Archie Shelton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Cd	Married

6.(b) Name of husband or wife: Nettie Shelton
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Aug 15 1879

8. AGE: Years: 65 | Months: 7 | Days: | If less than one day: hrs. min.

9. Birthplace: Charles Co Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Unknown.
13. Birthplace: Unknown.

MOTHER
14. Maiden name: Hannah Jackson
15. Birthplace: Maryland Md.

16. Informant: Stanley Penny
Address: Makon Springs Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mch 16 45 (month) (day) (year)
Cemetery or crematory: St. Charles
Location: Plymouth Md.

18. Funeral director: Stanley Penny
Address: Mason Springs Md.

19. 3/15/45 (Date rec'd by registrar) Henry Smallwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mch 13 19 45 at 7 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 40 to Mch 19 45
and that I last saw him alive on Feb 19 45

Immediate cause of death	DURATION
Cerebral Apoplexy	
Due to: Arteriosclerosis	
Due to: Over Infirmities	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. P. Bicknell M.D.
M. D. or other
Address: Marbury Md Date signed: Mch 15 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

02840

CERTIFICATE OF DEATH

Reg. Dist. No. 101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles.
City or town: Pomonkey.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles.
City or town: Pomonkey
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Julia Edward Swann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dora Swann
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Oct. 4. 1881

8. AGE: Years	Months	Days	If less than one day
63	5	27	hrs. min.

9. Birthplace: Newburg, Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farm.
FATHER 12. Name: Mathew Swann
13. Birthplace: Chas. Co. Md.
MOTHER 14. Maiden name: Annie Bridgett
15. Birthplace: Chas. Co. Md.
16. Informant: Mrs. Jord Swann.
Address: Pomonkey, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 3 45 (month) (day) (year)
Cemetery or crematory: Mt. Rest
Location: La Plata, Md.
18. Funeral director: Hunt & Ryan.
Address: Waldorf, Md.
19. 3/31/45 (Date rec'd by registrar) Mary Swann Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 1945, at 5 30/4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 1945 to March 31 1945 and that I last saw him alive on March 30 1945

Immediate cause of death	DURATION
Acute myocarditis	1 day.
Due to: Bronchopneumonia	2 days.
Due to:	
Other conditions: Chronic Bronchitis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hunt G. Swann M. D.
M. D. or other
Address: Indian Head Md. Date signed: 3/31/45

Evidence for addition of residence of deceased is shown on FILM No. G 9 4 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

02841

Reg. Dist. No. 101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: Marbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Marbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: --
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lorena Davis Swiford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thos. E. Swiford
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mch 6 1860

8. AGE: Years: 80 | Months: — | Days: 13 | If less than one day: ..... hrs. ..... min.

8. Birthplace: King George Co. Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jefferson H. Davis
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sophia Ann Davis
15. Birthplace: Clark Co. Virginia

16. Informant: Charlotte Barbour
Address: Rock Point Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mch 21 1945 (month) (day) (year)
Cemetery or crematory: Baptist.
Location: Marbury, Md.

18. Funeral director: Hunt & Ryon
Address: Waldorf Md

19. 3/24 19 45 (Date rec'd by registrar) Mary Lou Mudd Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mch 19 19 45 at 5 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1st 19 45 to Mch 19 19 45 and that I last saw her alive on Mch 18 19 45

Immediate cause of death	DURATION
Arteriosclerosis	
Valvular cardiac disease	
Due to: Chr. nephritis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. O. Bicknell M.D. M. D. or other
Address: Marbury Md Date signed: Mch 20 45

STATE OF MARYLAND—CERTIFICATE OF DEATH

12842

1. PLACE OF DEATH

County Charles — Registration Dist. No. 100

Village or City Faulkner — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 20 yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME George Weiland Jr.

(a) Residence: No. Faulkner Md. St., ____ Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Colored	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) Sept 6 - 1924

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	20	6	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Laborer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Farm Work

10. Date deceased last worked at this occupation (month and year) Mar 15-'45

11. Total time (years) spent in this occupation 4

12. BIRTHPLACE (city or town) Faulkner (State or country) Maryland

FATHER

13. NAME George Weiland

14. BIRTHPLACE (city or town) Wisconsin (State or country) Maryland

MOTHER

15. MAIDEN NAME Nellie Brown

16. BIRTHPLACE (city or town) Buddis Creek (State or country) Maryland

17. INFORMANT George Weiland (Address) Faulkner Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Smith Cemetery Md. Date 3/28, 1945

19. UNDERTAKER Hunter & Ryan (Address) Waldorf Md

20. FILED 3-26, 1945 — Julia H. Posey, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 25th (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from March 21, 1945, to Mar. 25, 1945

I last saw h. im alive on March 25, 1945; death is said to have occurred on the date stated above, at 10.30 p.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	Mar 21-'45

Other **Contributory Causes** of importance:

Name of operation — Date of ____

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) Ernest L Spencer Jr. M. D.

(Address) Bel Alton Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

02843

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Physicians Memorial Hosp.
How long in hospital or institution? 7 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Baby Juanita Joan Willett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-7-45

8. AGE: Years | Months | Days | If less than one day: 7 hrs. min.

9. Birthplace: La Plata, Charles, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Luther Joseph Willett
13. Birthplace: Chas. Co. Md

MOTHER
14. Maiden name: Blanche Atchenson
15. Birthplace: Geo. Co. Md.

16. Informant: Luther Joseph Willett
Address: Accokeek, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 3/8/45 (month) (day) (year)
Cemetery or crematory: Oakland
Location: Waldorf, Md

18. Funeral director: Hunt & Mason
Address: Waldorf, Md.

19. 3-8 19 45 (Date rec'd by registrar)
Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-7 19 45, at 5-05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-7 19 45, to 3-7 19 45
and that I last saw h.e.r alive on 3-7 19 45

Immediate cause of death	DURATION
Prematurity	6 mos.
Due to: Gestation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D.
M. D. or other
Address: La Plata Md Date signed: 3-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15